



# **Kansas Health Policy Authority**

## **Update on Kansas Medicaid and Federal Health Reform**

**Kansas State Nurses Association  
Legislative Advocacy Day  
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# Overview

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  - **Expected impact of 10% reduction in provider payments**
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# Overview of Kansas Health Policy Authority

- Established in 2005 to coordinate health and health care policy in Kansas.
- Single State Medicaid Agency
  - Directly administer medical programs
  - Pass-through federal funding for SRS, Aging, JJA to administer other portions
- Children's Health Insurance Program
- State Employee Health Plan
- State Employee Worker's Compensation
- Health Policy Analysis and Recommendations
- Primary Goals in 2010:
  - Manage Medicaid costs and support state's review of spending
  - Position Kansas for possibility of Federal health reform
  - Advance implementation of health information technology



# Public Insurance Programs in Kansas

- **Medicaid:** Free coverage for very-low income families, elderly and disabled
  - Federal government pays appx 60%; state pays 40%
  - Entitlement program: Anyone eligible is entitled to benefits if they enroll
  - Pregnant women and infants up to 150% FPL
  - Children: 100% or 133% of FPL, depending on age
  - Elderly and Disabled: income limits vary, 100 – 200% FPL
  - Adult Parents and Caregivers: appx. 30% FPL
  - “Medically Needy” – Adults with incomes above threshold who have high, ongoing medical costs
  - Childless adults not covered
- **CHIP:** Low-cost coverage for uninsured children in families that don’t qualify for Medicaid
  - Income limit: 250% of 2008 FPL (appx. 241% current FPL)
  - Premiums: \$20 - \$75 per-family, per-month, depending on income
  - HealthWave: State contracts with MCO; pays flat, capitated rate for each beneficiary – also serves 125,000 Medicaid children and families
  - Federal block grant funding:
    - Feds pay 72% in Kansas, up to grant limit; state pays 28%
    - Enrollment can be limited to available funds
- **MediKan:** Temporary coverage for disabled Kansans awaiting SSI Disability Determination.
  - 12-month lifetime limit on benefits
  - 100% funded by state of Kansas



# Circumstances Have Changed Dramatically Since 2005

- **New economy**
  - Immediate reductions in funding for KHPA operations
  - Reductions possible (now realized) in services in FY 2010 and beyond
  - Large structural deficit that grows substantially with expiration of Federal stimulus dollars in 2011
- **New state leaders**
  - Transition in KHPA leadership
  - Transition in statehouse since KHPA's founding
  - Ongoing review of KHPA's structure
- **New federal administration**
  - New President attempting to advance major health care reforms
  - Former Governor Sebelius in position of national leadership
  - Reform options address several of KHPA's health policy agenda items



## **KHPA's New Focus**



# Refocus resources on core program operations

- **Scale back communications, outreach and policy capacity**
  - Eliminate the policy division and Director's position
  - Layoff 5 staff in those
  - Reassign remaining staff to programs operations
- **Maintain capacity to implement savings and efficiencies identified through transformation and normal program operations**
- **Acknowledge the agency's core accountability to efficiency, transparency, and program improvement**
- **Develop new savings and efficiencies on a regular basis by looking at each program in a disciplined and systematic way**



# Position the State for National Health Reform

- **Ensure appropriate governance and financing for any expansion**
- **General goals in reviewing proposals**
  - Federal reform should maintain or reduce state cost
  - Preserve or enhance state flexibility
  - Consider leaving some big choices to states
  - Resolve conflicts between Medicare and Medicaid
  - Improve Federal support for Medicaid infrastructure
- **Looking ahead to the state's potential role post reform**
  - Legislative review of federal reforms
  - Implement specific reforms
  - Increase public accountability and confidence at state level
  - Continued focus on prevention and medical home
  - Managing costs and enhancing financial accountability
  - Addressing Medicaid's enhanced role with core safety net providers
  - Coverage no longer the core question in Medicaid policy



# Help Secure ARRA Funding for Health Information Exchange and Technology

- **ARRA and existing Medicaid statute include substantial funding for the development and advancement of a coordinated HIE and HIT strategy**
- **KHPA's objectives in developing a statewide plan are to achieve:**
  - a medical home
  - meaningful use among core Medicaid providers
  - efficiency and health-improving use of HIT for Medicaid recipients and the uninsured
- **KHPA has received a \$1.7 million grant (90% matching funds) from the Federal government to develop the State Medicaid Health Information Technology Plan**
  - Addresses need to focus attention on high volume Medicaid providers and those serving the uninsured
  - Includes a detailed assessment and review of the "As-Is" HIE/HIT landscape in providers offices around the state
- **Future grant awards will be used to implement a Medicaid HIT plan:**
  - upgrade KHPA's information systems to connect with the state HIE
  - administer 100% Federal incentive payments necessary to support the implementation of certified electronic health record (EHR) technology by eligible Medicaid providers.



# **KHPA Strategic Focus: Advancing a Medical Home**

- Developing a Medical Home for Medicaid and SEHP was part the KHPA health reform platform of the 2007 Legislative session
- KHPA worked with legislators and stakeholders to codify the definition of Medical Home in statute with SB 81 in 2008
- Kansas participated in the State Quality Institute in 2008-2009 with a project to create a medical home for children in Medicaid and CHIP
- KHPA revised plans for developing a Medical Home model of care with payment reform as a result of the budget deficit
- Participation in the State Quality Institute II continues in 2009-2010 with a project to develop a medical home pilot for high needs/high cost beneficiaries



# **KHPA Strategic Focus: Advancing a Medical Home**

- As participants in the State Coverage Institute the Kansas team visited Vermont to review how that state is operationalizing a Medical Home
- In 2009 Kansas procured a grant through NASHP to receive technical assistance by participating in the Consortium to Advance Medical Homes
- The Kansas state team is working to develop a plan to implement the Medical Home Model that will be shovel ready when funding becomes available
- The criteria for recognizing Medical Homes will incorporate the CMS definition of meaningful use of health information exchange
- KHPA is working in conjunction with KDHE and stakeholder groups to coordinate planning for HIT and Medical Home in Kansas



# **Budget Update:**

## **Medicaid provider rates and administrative capacity**



# Brief Overview of KHPA's Budget

- **KHPA's FY 2009 budget was about \$2.6 billion**
  - \$1.36 billion was non-SGF funding for KHPA medical programs
  - \$800 million was federal funds passed through to other Medicaid service agencies (SRS, KDOA, JJA, KDHE)
  - \$450 million was SGF funding for services and operations
- **KHPA programs and operations are funded separately**
  - FY 2009 operational funding was \$23 million SGF (now \$18 million)
  - Caseload costs are about 20 times larger than operational costs
  - Caseload savings cannot be credited to cost-saving operations
  - The federal government matches Medicaid operations at 50-90%
  - Operational costs for the state employee plan are funded off-budget through standard charges to agencies for each participating employee
- **KHPA budget reductions have hit Medicaid operations and services** Medicaid caseload protected due to Federal stimulus dollars
  - Provider payments reduced 10% across the Board
  - KHPA agency funding reduced 20% versus FY 2009 – limits Medicaid operations, customer and provider service, eligibility processing



# FY 2010 Governor's State General Fund Allotments *November 2009*

- **Caseload reductions**
  - Across-the-board 10% reduction in Medicaid provider rates
  - Limitation on MediKan benefits to 12 months
- **Administrative reduction of \$1.13 million SGF**
  - Total impact is \$2.5 million all-funds
  - Cumulative 20.5% reduction since approved FY 2009
  - Allotment represents 5% reduction on FY 2009 base
- **SCHIP reduction of \$1 million SGF**
  - Growing backlog may reduce pressure on funding
  - Waiting to see the impact of the January 1<sup>st</sup> expansion in coverage to children between 200% of the FY 2009 poverty level and 250% of the 2008 poverty level

# FY 2010 Operating Budget After Allotments

<b>FY 2009:</b>	<b>\$22,814,018</b>
<b>Rev. FY 2010:</b>	<b>\$18,145,291</b>
<b>Total Cuts:</b>	<b>\$4,668,727 (20.5%)</b>

KHPA Internal Administration  
Cut 22% from FY 2009

MMIS Contract:  
Cut 20% from FY 2009

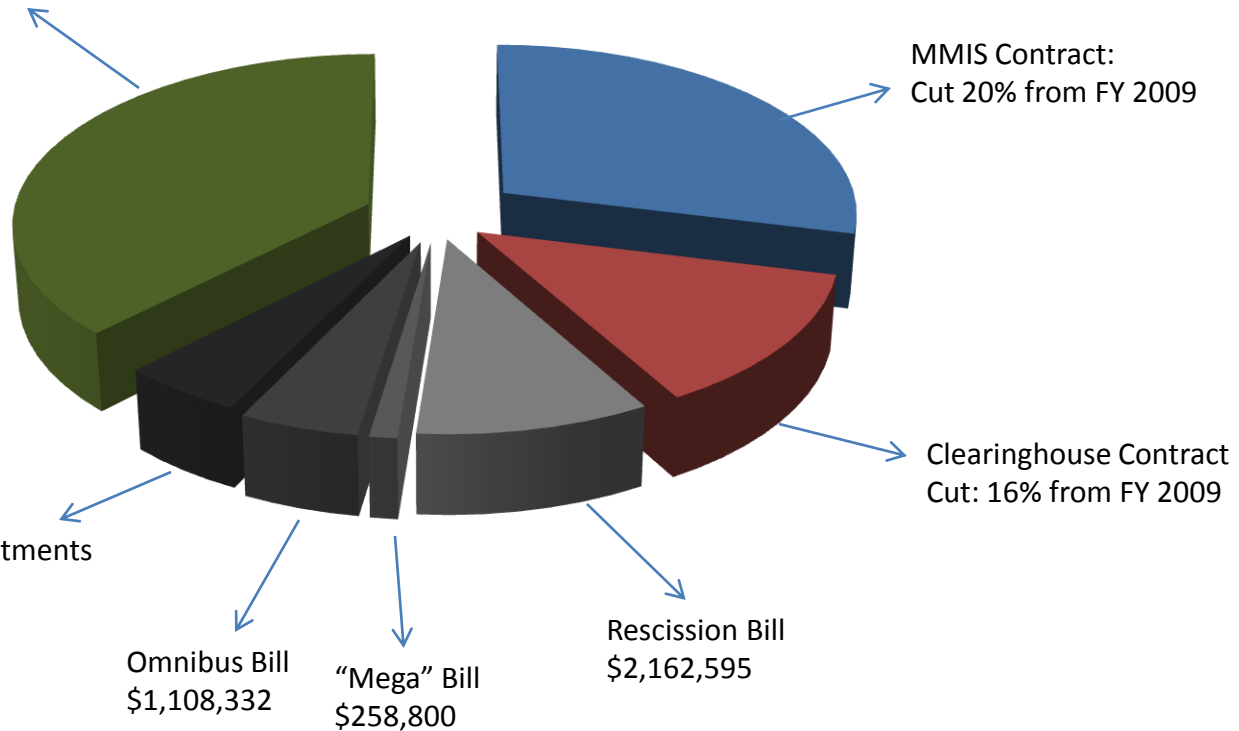
Clearinghouse Contract  
Cut: 16% from FY 2009

Rescission Bill  
\$2,162,595

"Mega" Bill  
\$258,800

Omnibus Bill  
\$1,108,332

November Allotments  
\$1,139,000





# Summary of November 2009 Allotment for KHPA Operations

- Freeze KHPA staff overtime and reduce KHPA staff through attrition (109,000) SGF
- Eliminate extra contract funding dedicated to the Clearinghouse eligibility backlog (140,000)SGF
- Cut State staff overtime dedicated to the Clearinghouse eligibility backlog (60,000) SGF
- Reduce scope of services in the Clearinghouse contract (197,000) SGF
- Amend verification policies and reduce call center capacity at the eligibility Clearinghouse (233,000) SGF
- Lapse funds from FY 2009 (150,000) SGF
- ~~Eliminate the call center for Medicaid providers and significantly reduce call center capacity for Medicaid beneficiaries (250,000) SGF~~

# Financial Impact of the 10% Payment Reduction

- At least \$18 million in savings to the state expected in FY 2010
- The current federal matching rate is approximately 70%
- Providers experience the all-funds reduction
  - Impact on providers is more than three times the savings to the state ( $1/.3 = 3.3$ )
  - Providers will experience a \$58 million reduction in payments in FY 2010
- Foregone Federal matching payments of approximately \$40 million in FY 2010
- The impact in FY 2011 will be more than twice as great if the reductions continue
  - Full year impact on providers would be at least \$200 million (\$70 million SGF, \$130 million Federal)
  - ARRA stimulus payments expire in December 2010, after which the state match reverts to about 60%



# **Looking Ahead: Additional (or Alternative) Sources of Savings in Medicaid**



# Reducing Medicaid Spending: Overview

- **Medicaid spending is determined by four key factors**
  - **People** covered, e.g., elderly, disabled, children and families, MediKan, foster care, etc.
  - **Services** provided, e.g., hospital services, pharmacy, mental health, nursing homes, community-based care, home health, hospice, etc.
  - **Rates** paid to each type of provider
  - **Utilization** of each service by each beneficiary
  
- **Opportunities for reductions in spending differ**
  - People covered
    - ARRA requires states to maintain eligibility through January 1, 2011
    - House and Senate health reform bills would extend that requirement indefinitely
  - Services provided
    - Some of the most expensive services are mandated by Federal statute
    - Optional services are not protected in ARRA
  - Rates
    - Rates are set, by and large, by fee schedule
    - Current ten percent reduction is at the upper end of imposed cuts nationally
  - Utilization of services
    - Health care management is intended to reduce unnecessary care and improve quality prevention



# Reducing Medicaid Spending: Health Care Management and Quality Improvement

- **Recent KHPA initiatives**
  - Health Promotion for Kansans with Disabilities Transformation Grant
  - Enhanced Care Management Pilot Project
  - Community Health Care Record Pilot Project
  - Commonwealth State Quality Institute Phase I & II
  - Vermont Medical Home Technical Assistance Initiative
  - National Academy of State Health Policy State Consortium to Advance the Medical Home for Medicaid and CHIP Programs
- **KHPA Board request to review the net impact of HealthWave managed care**



# Reducing Medicaid Spending: Health Care Management and Quality Improvement

- **Recent Measures Taken by Administrative Action**
  - Transformation Recommendations Implemented
    - Reasonable pricing requirements for durable medical equipment
    - Outsourced management of non-emergency transportation
    - Developed diabetes management initiative for home health
    - (Pricing reforms in home health are in process)
    - Published performance and quality data for HealthWave
    - Established the Mental Health Advisory Committee
    - Automated Prior Authorization for Select Pharmaceuticals
    - Increased Presumptive Eligibility Sites



# Reducing Medicaid Spending: Health Care Management and Quality Improvement

- **Reduction Options Included in FY 2011 Budget Submission**
  - Streamline Prior Authorization in Medicaid
    - \$243,000 SGF/ \$952,000 AF
  - Mental Health Pharmacy Management
    - \$800,000SGF/ \$2.0M AF
  - Align Professional Rates in Medicaid
    - \$ 1 M SGF/ \$ 2.8 M AF (Corrected)
    - Implemented as a part of the 10% reduction



# Cost-Saving Measures Taken by Other States

- **Options Kansas Medicaid has already taken**
  - Reductions in provider rates
  - Placing limits on community based long term care services, home health services, and private duty nursing
  - Intensifying prescription drug utilization and cost control initiatives
  - Chronic care management
  - Behavioral health utilization review
  - Post payment and hospital outlier review
  - Reduction in MCO administrative reimbursement
- **Other options**
  - Long term care managed care
  - 30 day no-readmit hospital policy for the same diagnosis
  - Coordination of behavioral health with physical health care
  - Incorporation of durable medical equipment costs into Home Health Nursing Home per diems
  - Eliminating optional services, e.g., hospice
  - Imposing new or higher copayment requirements, e.g., for pharmaceuticals



# Potential Federal Reforms



# Positioning the State for Possible Reforms

- KHPA advocates neither for nor against federal reforms
- KHPA is responsible for programs greatly affected by reform, and would likely to be tasked with implementing some of the most significant reforms
- KHPA's efforts are focused on reviewing reform proposals for their impact on Kansas state expenditures, on preserving state flexibility in Medicaid, and on identifying expected operational issues



# Presumed Goals of Federal Reform

- **Extend “group” rate for insurance to everyone**
  - Eliminate pre-existing condition restrictions and premium rating based on health risks
  - Insurance Exchanges: private, group-like coverage for individuals and many small businesses
- **Buy or subsidize coverage at the group rate**
  - Greatly expand Medicaid to cover the lowest-income Americans
  - Phase out of Federalize Children’s Health Insurance Program (CHIP)
  - Public subsidies to help others buy private insurance
- **Stabilize private insurance markets through participation**
  - Individual mandate/penalties
  - Employer mandate/penalties



# Medicaid Expansion

## House

- Expansion in 2013
- All individuals up to 150% FPL (including childless adults)
- All newborns who lack “acceptable coverage”
- Feds cover 100% of cost for expansion group in 2013; 91% in 2015.
- Increase payment rates to primary care providers to 100% Medicare rates by 2012

## Senate

- Expansion in 2014
- All individuals under 65, up to 133% FPL (including childless adults)
- Feds cover 100% of cost for expansion group in 2014-2016
  - 2017: current rate + 34.3%
  - 2018: current rate + 33.3%
  - 2019+: current rate + 32.3%
- Some state flexibility in coverage options for newly-eligible; must meet minimum standards



# Children's Health Insurance Program

## House

- Repeal CHIP
- Require CHIP enrollees with incomes over 150% FPL to obtain coverage through an exchange, 2014
- Enrollees with incomes between 100% – 150% shifted to Medicaid
- Coverage offered through exchanges must meet minimum standards

## Senate

- Require states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019
- Extend funding for CHIP through 2015
- Benefit package and cost-sharing rules continue as under current law
- In 2015, increase federal CHIP match rate by 23 percentage points, up to maximum of 100%
- Eligible children who can't enroll due to enrollment caps eligible for tax credits in the state exchanges



# Insurance Exchanges

## House

- Create National Health Insurance Exchange, with option for states to create their own
- Individuals and employers can buy qualified insurance
- Seamless, web-based coordination of applications for federal subsidies and Medicaid coverage through the exchange
- Phase-in employer eligibility, starting with smallest
- Offers private health plans and government “Public Option”

## Senate

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP), with option for state to allow federal government to establish the exchange
- Administered by governmental agency or non-profit
- Available to individuals and small businesses (up to 100 employees)
- States can allow larger businesses to buy coverage in SHOP in 2017
- States may form regional exchanges with other states or within the state
- Federal funding available to establish exchanges through 1/1/2015



# Potential Impact on Kansas

- Likely net savings to state: \$0 to -\$50 million per-year
  - Based on House-passed version versus Senate Finance Committee version
  - Some high-cost beneficiaries with intermittent coverage shifted to private insurance
  - Higher federal payments for expansion group and CHIP (greater than 90%)
  - Other savings, incl. federal rebates for Rx drugs
- Reduce number of uninsured
  - Currently appx. 335,000 uninsured (12% population)
  - Bills might reduce uninsured by -190,000 (SFC) to -240,000 (House)
- Growth in Kansas Medicaid
  - Net: +60,000 (SFC); +100,000 (House)
- Disproportionate Share Payments (DSH) to hospitals
- “Uncompensated Care” greatly reduced
- Higher payments for preventive care fully funded by federal government
- Expanded role for Medicaid in funding the health care safety net



# State Policy Choices and Challenges

- Design, governance and implementation of exchanges (Senate)
- Coordination of exchanges with Medicaid to ensure continuous coverage and appropriate source of payment
- Benefit package design for Medicaid expansion group (level of state choice unclear)
- Provider payment rates for expanded program
- New role for Medicaid in health care system
- Controlling growth in future costs



# Alternatives

- **Reduce the *price* of health care to make it more accessible to the poor**
  - Expand physical safety net system to ensure access to primary care for the uninsured
  - Expand the number of providers to create more price competition in health care
  - Malpractice reforms
- **Reduce *variation* in the price of insurance**
  - Reforms to get insurance companies out of the business of avoiding customers
  - Reduce or eliminate experience rating, pre-existing conditions, or require guaranteed issue
  - Expand, fund and manage the high risk pool
  - Reinsurance mechanisms
- **Address consumer *behaviors***
  - Transparency in price and quality of health care
  - Address true cost drivers: smoking, over-eating and inactivity

*Coordinating health & health care  
for a thriving Kansas*



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